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Adolescent Perspectives on Social Support Received in the Aftermath of Sexual Abuse: A Qualitative Study

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Abstract The extent and quality of social support provided to young survivors of sexual abuse (SA) have only rarely been examined. This qualitative study aimed to investigate adolescent perspectives on social support received in the aftermath of SA. A total of 26 sexually victimized adolescents (15–18 years old) participated in a qualitative face-to-face, in-depth interview that focused on perceived social support. Qualitative content analysis was conducted as per Mayring (2008) using the qualitative data analysis program ATLAS.ti. In addition, quantitative correlational analyses were conducted to identify characteristics of SA and their associations with perceived social support. Although participants perceived parental support as the most necessary type of support, they were much more satisfied with support from peers. In particular, adolescents stated that they wished they had received more emotional support from their parents in order to better cope with the abuse. About half of participants reported having received counseling, and counseling was seen as very helpful in dealing with the consequences of SA. Only a few adolescents mentioned their school as a source of support. Intra-familial abuse, younger victim age at the time of abuse, an adult perpetrator, and severe abuse were all negatively associated with satisfaction with perceived support. Our results suggest that support for young survivors of SA needs to be improved. Prevention of SA needs particular focus on improving parental reactions to SA, facilitating access to professional support, and raising teacher awareness of the importance of their role in the provision of support for sexually victimized children.

Keywords Child sexual abuse · Sexual victimization · Adolescents · Qualitative research

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Introduction

The International Society for the Prevention of Child Abuse and Neglect (2010) defines sexual abuse (SA) of a minor as involving a child in sexual activity that the child does not fully comprehend, is unable to give informed consent to, is not developmentally prepared for or is enforced without the child's consent. While most experts in the field agree that SA of a child or adolescent comprises both contact (e.g., forced intercourse, unwanted touching) and non-contact forms (e.g., verbal sexual harassment; exhibitionism) of sexually abusive behaviors (Finkelhor, 2009; Finkelhor, Hamby, Ormrod, & Turner, 2005; Leeb, Paulozzi, Melanson, Simon, & Arias, 2008), some include only SA by caregivers, but not SA by strangers or other children (Leeb et al., 2008).

Due to variations in definition, estimates of prevalence vary considerably (Schönbucher et al., 2011). In a recently published systematic review by the World Health Organization (2005),

mean lifetime prevalence estimates were reported to be 20 % for girls and 8 % for boys. In most cases perpetrators are male family members or acquaintances (Finkelhor, Ormrod, Turner, & Hamby, 2005; Lampe, 2002; Madu & Peltzer, 2001). While gender has been found to be the strongest predictor of SA, family characteristics such as single parent families or emotional neglect have also been found to be significantly related to SA, both with regard to victims (e.g., Laaksonen et al., 2011; Turner, Finkelhor, & Ormrod, 2007) and perpetrators (Whitaker et al., 2008).

There is strong evidence that SA in childhood or adolescence is a serious risk factor for mental illness (WHO, 2005). It has also been shown that social support during or after SA can considerably alleviate negative repercussions for mental health (Tremblay, Hébert, & Piché, 1999; Yancey & Hansen, 2010). Social support is defined as the exchange of helping behaviors in social relationships (Stroebe, Jonas, & Hewstone, 2003), a process that creates a social network of potential supporters (Kienle, Knoll, & Renneberg, 2006). Social support has different functional components including emotional (provision of caring), informational (provision of information or advice), and instrumental support (provision of material support) (Kienle et al., 2006). With regard to SA, social support is often described as believing what the victim is claiming, taking protective actions, and providing emotional support (e.g., Lovett, 1995; Pintello & Zuravin, 2001). It is presumed that social support has a buffering effect against the sexual trauma and facilitates a child's adaptive coping (Marivate, 2007).

Despite the importance of social support for coping with SA, studies investigating the victimized child's and adolescent's experience of received social support are rare. To date, most studies have either examined adult samples (e.g., Arata, 1998) or investigated the perspective of the children's parents on the parental support they provided (e.g., Alaggia, 2002). While the validity of retrospective accounts from adults is believed to be diminished by recall bias (Crisma, Bascelli, Paci, & Romito, 2004), research findings have suggested that parents participating in research tend to overstate the degree of support they provided to their victimized child (Morrison & Clavenna-Valleroy, 1998). Moreover, involving the victim's parents in research is only reasonable if parents are not themselves involved in the abuse.

On the other hand, studies that have examined sexually victimized children and/or adolescents have largely involved SA cases that were reported to local authorities (e.g., child protection services, police) (e.g., Hershkowitz, Lanes, & Lamb, 2007; Rosenthal, Feiring, & Taska, 2003). As only the minority of SA cases are reported to local authorities (London, Bruck, Wright, & Ceci, 2008), the results of such studies cannot be generalized. Furthermore, one can assume that most referrals to professional agencies are initiated by the children's parents, and it is likely that parents of such children are more supportive than parents who do not bring their child to the attention of local authorities.

It has been suggested that studies that recruit sexually victimized adolescents from the general population are the most accurate way of researching SA in children and adolescents (e.g., Crisma et al., 2004; London et al., 2008). Due to its relative recency, one can expect recall bias in adolescent samples to be less than that observed in adult samples. Furthermore, adolescents, in contrast to younger children, are able to participate in studies without their parents' knowledge or consent. The inclusion of children who have been victimized by a parent or who have not yet disclosed the abuse is only possible if parental consent is not required for study participation. However, despite their importance, there are few studies on disclosure that included adolescents. To our knowledge, only Crisma et al.'s (2004) qualitative interview study involved minors that were recruited from the general population. Crisma et al. reported that most participants were satisfied with parental support. However, findings from studies with reported SA cases are inconsistent, indicating that between one third and the majority of children received some kind of support from their parents (e.g., Hershkowitz et al., 2007; Sirles & Franke, 1989). Most studies investigating parental support have included intra-familial and extra-familial SA cases. Support has only been assessed among parents who were not the perpetrator.

The support provided by other confidantes—such as friends, professionals or other relatives—has been neglected. Crisma et al. (2004) reported that most adolescents were dissatisfied with the support they received from professionals such as physicians or counselors. Peer support has only been investigated by Rosenthal et al. (2003). They found that pre-pubertal children were primarily supported by parents, whereas adolescents also received some support from peers. One drawback of the study was that the researchers applied a standardized instrument for general social support. It can be assumed that abuse-related support may be a more valid indicator of support received in the aftermath of sexual assault than general social support.

In order to improve support for young survivors of SA, it is not only important to investigate who provides social support, but also to assess what kind of support survivors of SA find specifically helpful in coping with the abuse, and what kind of support they are missing. The few findings from previous research have suggested that counseling/psychotherapy, having somebody to talk to, and being believed are the most important types of support that young survivors of SA require (Crisma et al., 2004; Morrison & Clavenna-Valleroy, 1998). However, to what degree these aspects of support are provided by the victims' social network has not yet been systematically examined.

Also, predictors of SA-related social support have been examined only marginally. The results of the few studies investigating factors related to support received indicated that parents

were more likely to provide support to victims who experienced mild (e.g., fondling through clothes) versus severe forms of SA (e.g., genital penetration) (Hershkowitz et al., 2007; Sirles & Franke, 1989). Furthermore, parental response to disclosure tended to be less supportive if they know the perpetrator (Hershkowitz et al., 2007). Least supportive reactions are to be expected from mothers who are in an on-going intimate relationship with the perpetrator (Everson, Hunter, Runyon, Edelsohn, & Coulter, 1989; Sirles & Franke, 1989). Previous findings regarding the association between the support provided and a child's age at the time of abuse are inconsistent. Rosenthal et al. (2003) and Sirles and Franke (1989) reported more supportive parental reactions to younger rather than to older children (Rosenthal et al., 2003; Sirles & Franke, 1989) whereas Everson et al. (1989) found that older children were more supported by their mothers than younger children. No significant associations were identified with regard to gender or sociodemographic characteristics such as ethnicity or socioeconomic status (SES, Rosenthal et al., 2003; Sirles & Franke, 1989).

In summary, although social support has been shown to be an important predictor of psychological recovery after SA, the extent and quality of the social support provided to young survivors of SA have yet to be sufficiently examined. Therefore, the current qualitative study was designed to investigate adolescents' perceptions of the social support they received in the aftermath of SA. According to the International Society for the Prevention of Child Abuse and Neglect (ISPCAN) (2010), SA is defined as involving a child (<18 years) in non-contact (e.g., sexual harassment, nude photographs) or contact (e.g., intercourse) sexual activity that the child does not fully comprehend, is unable to give informed consent to, is not developmentally prepared for, or is enforced without the child's consent. Sexual victimization by caregivers, peers, and strangers was included in the definition. The study addressed the following research questions:

(1) How do adolescents perceive the support they received in the aftermath of SA? (e.g., What kind of support did they receive? Who were the main support providers?)
(2) Do adolescents report insufficient support? (e.g., What kind of support were they missing? From whom would they have liked more support?)
(3) What kind of support do they regard as most necessary for young survivors of SA?
(4) Are there any associations between adolescents' perception of received support and characteristics of SA (e.g., severity of SA)?

Our thesis was that sexually-victimized children and adolescents require a network of socially supportive people, who provide different aspects of social support. It was further hypothesized that victims of SA often perceive the support they received as insufficient for coping with the abuse, and that improvements in the provision of support are required to minimize negative repercussions on mental health.

Method

Participants

We sought to recruit sexually victimized adolescents from the general population in order to avoid the above-mentioned biases found in clinical samples. A total of 26 adolescents participated in the study. Fourteen responded to notices in the daily newspaper, four learned about the study via the study flyer, three saw the link to the study on a website for professional services, three were referred by the child protection team of the University Children's Hospital Zurich, and two were encouraged to participate by acquaintances who knew of the study. Twenty-three (88.5 %) participants were female and three (11.5 %) were male. Participants' age ranged from 15.4 to 18.3 years ($M = 17.0$ years). Twenty-two were Swiss, while four were of non-Swiss nationality. Thirteen participants lived with both parents at the time of study participation, six lived with their mother and her partner, three lived only with their mother, and four lived without parents (e.g., assisted living in the community). All participants knew and had regular contact with both parents. Ten participants were still in school, 15 in an apprenticeship or other vocational training, and one was still looking for an apprenticeship position. Seven (26.8 %) participants were of low SES, 15 (57.7 %) of middle, and four (15.8 %) of upper social class.

All participants contacted the authors because of a single type of sexual violence they had experienced. However, on average, participants had experienced 2.6 additional types of sexual violence (e.g., one participant contacted an author because she had been raped by an acquaintance, but she also had been sexually harassed by school-mates). Participants were asked which SA event they considered the most severe they had experienced. In all but one case, participants rated as most severe the same SA event that had prompted them to contact the authors. The most severe types of SA experienced by participants ranged from sexual harassment to completed rape. Over half of the participants had experienced contact SA without penetration, while more than one third had actually been raped (see Table 1). Eight participants had experienced intra-familial sexual violence, while six had been sexually assaulted by a stranger. Half of the sexual assaults were committed by adolescent perpetrators. All perpetrators were male and the age of participants at the time of SA ranged from three to 17 years ($M = 11.7$ years).

Procedure

A one-time, qualitative, in-depth interview was used for data collection to allow for both detailed and direct assessment of adolescents' subjective experiences pertaining to the support

Table 1 Types of sexual abuse (SA) and relationship to perpetrator

	N
Type of SA	
Contact without penetration	14
Penetration	9
Attempted penetration	2
Non-contact	1
Singular SA	9
Repeated SA	17
Perpetrators	
Male	26
Female	0
Unknown adolescent	6
(School) friend	5
Biological father	4
Partner of mother	3
Boyfriend	2
Friend of parents	2
Colleague at work	1
Uncle	1
Caretaker in children's home	1
Unknown adult	1

they received following SA. The above-mentioned recruitment strategies were adopted.

The recruitment materials (e.g., flyer, link on websites) contained a written description of several types of SA (e.g., exhibitionism, rape). Adolescents were asked whether they had experienced one or more of the listed events or had experienced some other type of sexual violence or harassment. Further, the study objectives and procedures were described and anonymous participation was guaranteed. Adolescents were also informed that their travel expenses would be reimbursed and that they would receive two cinema tickets as a thank-you for their participation.

For practical reasons, recruitment was focused on the Canton of Zurich, Switzerland.[1] The inclusion criterion for age was set at 15–18 years (between the ages of 15 and 18, parental consent is not a prerequisite for study participation according to Swiss law). Adolescents who were interested in participating in the interview were asked to contact one of the authors (VS or MAL) via phone or email. If the authors were emailed, a telephone appointment was arranged. During the first telephone contact, adolescents were provided with comprehensive information about study participation and the same information was sent in writing via mail or email.

Most interviews were conducted at the University Children's Hospital Zurich by one of the authors (VS). Two participants preferred to be interviewed at home. Before the interview began, participants were informed about the interview procedure and reassured that they were allowed to take a break or stop the interview whenever they wanted. Participants were then given an informed consent form to sign. The interviews lasted, on average, roughly 2 h (range 1–3 h). After the interview, participants were offered short-term counseling or a referral to a support service for victims of sexual assault to obtain psychosocial support if required.

Prior to data collection the study was approved by the Ethics Committee of the Canton of Zurich.

Measures

There were two parts to the in-depth interview. The first part consisted of standardized questions and measures addressing family situation, sociodemographics, sexual victimization, and general and mental health. The second part was a qualitative semi-standardized interview with questions on disclosure and received support. In this article, qualitative data on received support is presented, with the qualitative data on disclosure published elsewhere (Schönbucher, Maier, Mohler-Kuo, Schnyder, & Landolt, 2012). The primary aim of the study was to collect data on participants' perception of the support they received, and not objectively to assess what support they actually received. Like other self-report assessment instruments, in-depth interviews only allow for the assessment of an individual's perception of a subject. This part of the interview focused on the following questions: (1) Were participants satisfied with the support they received? (2) From whom did participants receive support? (3) Would participants have wished for additional or better support? (4) What kinds of behavior from others did participants perceive as supportive and helpful? (5) Were participants confronted with non-supportive behaviors? And (6) What kinds of support do participants think is most necessary for survivors of SA in general?

Quantitative data presented in this article refer to characteristics of the sexual assaults and the socioeconomic situation of participants. The following standardized measures and questions were applied to collect quantitative data.

Sexual Victimization

Data on sexual victimization were collected using a German version of the Sexual Assault Module of the Juvenile Victimization Questionnaire (JVQ) (Hamby, Finkelhor, Ormrod, & Turner, 2004). We performed an authorized translation of the original English version of the JVQ using Mallinckrodt's guidelines (Mallinckrodt & Wang, 2004). This procedure included the following steps: (1) two independent translations were generated from English to German by native speakers of the target language; (2) from these, a consensus German version was created; (3) a back translation into English of the consensus

[1] Switzerland is divided into 26 territorial divisions, which are called cantons.

version was drafted by an independent native speaker; (4) the consensus German version and the back-translated English version were reviewed and compared by the original author; (5) questions from the original author were reviewed to produce the final German version; and (6) the JVQ authors assessed and approved the final translated version.

The JVQs Sexual Assault Module is a checklist consisting of seven screening questions about seven different types of SA (e.g., sexual harassment, rape). If a child responds "yes" to one of the screening questions, a series of follow-up questions on specific characteristics about the assault are asked (e.g., how many times was the child victimized; how old was the child when the abuse started and how old when it ended; and what was the child's relationship to the perpetrator). This questionnaire has demonstrated good reliability and validity in a U.S. national random sample of 10–17 year old adolescents (Finkelhor, Hamby et al., 2005). The wording of the questions for lifetime prevalence was as follows:

1. Has a grown-up you know ever touched your private parts when you didn't want it or made you touch their private parts? Or has a grown-up you know ever forced you to have sex?
2. Has a grown-up you did not know ever touched your private parts when you didn't want it, made you touch their private parts or force you to have sex?
3. Now think about kids your age, like from school, a boy friend or girl friend, or even a brother or sister. Has another child or teen ever made you do sexual things?
4. Has anyone ever tried to force you to have sex; that is, sexual intercourse of any kind, even if it didn't happen?
5. Has anyone ever made you look at their private parts by using force or surprise, or by "flashing" you?
6. Has anyone ever hurt your feelings by saying or writing something sexual about you or your body?
7. Have you ever done sexual things with anyone 18 or older, even things you both wanted? (Statutory Rape & sexual misconduct).

After assessing these seven items, we listed all reported experiences of sexual victimization for each participants and categorized them into non-contact SA, contact SA without penetration, attempted penetration, and penetration (see Table 1).

Socioeconomic Data

SES was calculated by adding the scores for paternal occupation and maternal education, both rated on 6-point scales. Consequently, SES scores ranged from 2 to 12 points and were categorized into three social classes: 2–5 = low social class; 6–8 = middle social class; and 9–12 = upper social class. This measure has been shown to be a reliable and valid indicator of SES in our country (Landolt, Nuoffer, Steinmann, & Superti-Furga, 2002). Additionally, participants were asked about the educational level, nationality, and marital status of their parents.

Data Analysis

Qualitative Analysis

After the semi-standardized qualitative parts of the interviews were transcribed, qualitative inductive content analysis was conducted in accordance with Mayring (2008), using the qualitative data analysis software ATLAS.ti version 5.2 (www.atlasti.com). Mayring's (2008) qualitative research approach is one of the most established qualitative methodologies in social research in the German-speaking countries of Europe. Based upon the research questions, material in written form was analyzed by stepwise inductive construction of categories (codes), to which statements in the text are then assigned. The process of categorization and interpretation proceeds close to the material and is often not theory-driven. After 10–50 % of the material is analyzed, the categories are re-evaluated and revised, if necessary. They also can be grouped into larger categories (families). At the end of the categorization process, intercoder reliability of categories is checked. If intercoder-reliability is satisfactory, quantitative analyses of categories can be conducted to test research questions (Mayring, 2008). It is the quantification of qualitative results that distinguishes Mayring's methodological approach from other qualitative analysis techniques such as the Interpretative Phenomenological Analysis by Smith, Flowers, and Larkin (2009), which focuses more on illustrative descriptions and interpretations of key phenomena identified in the material.

One author (VS) coded the interviews. Following this process, two authors (VS, MAL) jointly grouped codes into categories and subcategories. The main categories that could be defined were as follows: people who exhibited supportive behaviors, those who exhibited non-supportive behaviors, and types of behavior that participants perceived as supportive, as non-supportive, and as most important.

Categories are listed and defined in Table 2. Categories were listed if they were mentioned by at least three participants. Seven subcategories were constructed for groups of supportive or non-supportive people, nine for supportive behaviors, and eight for non-supportive behaviors.

Intercoder reliability of the defined categories was tested according to the recommendations of Lombard, Snyder-Duch, and Bracken (2010): Two authors (TM, US) who had been involved in neither the analysis nor construction of categories were given a random sample of 20 % of the quotations that had previously been coded by the first author. After they were instructed about the definition of categories, they were asked to assign quotations to the categories. The three code assignment ratings (VS and MAL, TM, and US) achieved excellent intercoder

Table 2 Definition of categories for supportive or non-supportive people and behaviors

Categories for supportive or non-supportive people	Allocated codes
1 Peers	Friend, school friend, flat mate, colleague from work
2 Parents	Mother, father, parents[a]
3 Siblings	Sister, brother
4 Intimate partner	Boyfriend, girlfriend
5 Counselor, psychotherapist	Counselor, psychologist, psychiatrist, psychotherapist, psychiatric institution
6 School	Teacher, school social worker
7 Other people	Relative, music teacher not associated to school, girlfriend of brother, mother of a friend, physician, superior, clergy person, neighbour, police, caretaker
Categories for supportive behavior	**Allocated codes**
1 Empathy	Participant felt supported because somebody showed kind of empathic behavior such as listen to the participant, being there for conversations, understanding the participant's state of mind, giving comfort and could be trusted by the participant
2 Referral to professional support	Participant was referred by somebody to a service for victims of sexual violence, to a counselor, a psychiatrist, a psychotherapist, or a psychiatric institution (excluded are referrals to lawyers, which are allocated to category 8)
3 Intervening behavior towards perpetrator	Participant felt supported because somebody made some action against the perpetrator. E.g., broke up her/his friendship with the perpetrator, intervened during SV was happening
4 Solidarity	Solidarity with other victims of SV. Participant could exchange and talk with other people who experienced sexual violence
5 Encouragement of disclosure	Participant was encouraged by somebody to disclose SV to somebody (e.g., a parent, teacher) who could help the participant
6 Reassurance that the victim was not to blame for SV	Participant was reassured by somebody that she/he was not responsible for SV and that only the perpetrator was to blame
7 Reinforcing the victim's self-confidence	Participant felt reinforced by somebody in her/his self-confidence
8 Assistance to initiate legal steps	Participant was helped by somebody to report SV to the police, was referred by somebody to a lawyer, or was given legal advice
9 Assistance with coping	Participant said that somebody helped her/him to cope with SV
Categories for non-supportive behavior	**Allocated codes**
1 Lack of empathy	Somebody did not show the necessary empathic behavior, e.g., somebody was not there for the participant when she/he wanted to talk to her/him, participant did not felt understood by somebody, or participant would have wished to receive more attention
2 Denying of SV	Somebody knew about the SV but was in denial about the abuse or did not believe the participant that she/he had been sexually assaulted
3 No protection	Somebody did not protect the participant from the perpetrator although she/he would have been able to do so
4 Emotional instability	Participant said that somebody was emotionally too instable in order to be able to support the participant, either because the person had already psychological problems before or at the time of the SV (e.g., depression, drug abuse, feeling emotionally dependent on the perpetrator), or the person felt too upset by the SV that she/he could not give enough support to the participant
5 Short-term support only	Somebody provided some support to the participant for a certain time after the abuse but discontinued assistance after a while, often because the person underestimated the psychological consequences of the SV for the participant or because the person tabood SV
6 Not realizing that the victim was in a bad state of mind	Participant would have wished that somebody would have realized that she/he was very upset, that this person would have asked her/he what the matter with her was, so that the participant would have felt able to disclose SV
7 Blaming the victim	Somebody blamed the participant for SV
8 Taking the perpetrator's side	Participant felt that somebody was not on her/his side but on the perpetrator's side (e.g., somebody defended the perpetrator)

SV sexual victimization

[a] When participants did not differentiate between her/his mother or father but just talked from his/her parents

reliability, as indicated by a Krippendorff's alpha of 0.98 (Hayes & Krippendorff, 2007).

In the Results section, the results of qualitative analyses are illustrated by quotations from participants. Participants are numbered from *P1* for participant 1 to *P26* for participant 26. Quotations from the interviewer are indicated by an *I*.

Quantitative Analyses

To identify SA characteristics associated with aspects of perceived support, quantitative correlation analyses were performed. The following variables were created to test for associations: Did participants in any way claim insufficient support (yes = 1/no = 0); did participants claim insufficient support from parents (yes = 1/no = 0); did participants claim insufficient support from peers (yes = 1/no = 0); did participants claim insufficient support from their school (yes = 1/no = 0); number of groups of people (e.g., peers, parents) providing insufficient support; SA singular (= 0) versus repeated (= 1); SA non-penetrating (= 0) versus penetrating (= 1); severity of SA (non-contact SA = 0, contact SA without penetration = 1, contact SA with penetration = 2); perpetrator extra-familial (= 0) versus intra-familial (= 1; defined as SA committed by a person belonging to the core family); age of the victim at the time of SA; age of the perpetrator at the time of SA (<18 vs. ≥18 years).

All quantitative analyses were performed using the statistical package PAWS for Windows, release 18.0 (SPSS Inc., Chicago, IL). For sample description, tables of frequencies and descriptive statistics were used. To test for associations between characteristics of SA and perceived support, Spearman correlations were performed. All analyses were two-tailed, and $p < .05$ was considered statistically significant, while $p \leq .10$–$.05$ was considered indicative of a statistical trend.

For practical reasons, both quantitative and qualitative analyses only were performed for the SA event that participants reported as being the most severe. Due to the small number of male participants, analysis of gender differences was not feasible.

Results

Adolescent Perceptions of Support Received

All participants mentioned at least one person from whom they had received support, except for one girl who had experienced non-contact SA (verbal sexual harassment). This girl said that she had been able to cope with the assault on her own and, thus, had not felt any need for support. On average, participants mentioned 2.7 groups of people who were supportive of them to at least some degree.

Table 3 lists people who were at least somewhat supportive. Peers were the most frequently mentioned source of support

Table 3 Persons perceived by participants as at least partly supportive and types of received support

Persons perceived as (partly) supportive	Type of received support (*N* = number of participants who mentioned the specific type of support)								
	Empathy	Referral to professional support	Intervening behavior towards perpetrator	Solidarity	Encouragement of disclosure	Reassurance that the victim was not to blame for SV	Reinforcing the victim's self-confidence	Assistance to initiate legal steps	Assistance with coping
Peers ($N^a = 18$)	14	–	2	5	2	–	1	–	–
Parents ($N = 13$)	9	4	2	–	–	–	1	4	2
Counselor, psychotherapist ($N = 13$)	3	3	–	–	–	1	1	–	2
Intimate partner ($N = 8$)	5	–	1	–	–	2	1	–	–
Siblings ($N = 5$)	5	–	2	–	–	2	–	–	–
School ($N = 5$)	–	2	1	–	1	–	–	–	–
Other people ($N = 7$)	3	3	–	1	1	–	–	–	–
Total[b]	23	9	8	6	4	4	4	4	3

SV sexual victimization

[a] Number of participants who mentioned a specific group of people as being (partly) supportive to them. *N* does not have to be equal to the total of types of received support that were mentioned for a specific group of people for two reasons: (1) multiple answers were possible and (2) Table includes only categories of types of received support that were mentioned by more than two participants

[b] Number of participants who mentioned the specific type of support independent of the group of supportive people. The total *N* does not correspond with the total of the mentions of a specific type of support for the specific groups of supportive people due to multiple answers

($n = 18$), and support from them was seen by most participants as very helpful for coping with SA. An 18-year-old girl who was raped by her boyfriend answered the interviewer's question about whom she had received support from after SA: (P4) "From a friend of mine. She just hugged me and comforted me when I told her." Months after the abuse, she still felt well supported by her friends: (I) "Do you still feel supported by her?" (P4) "Yes. (…). Yes, my friends are there for me."

Participants less frequently perceived parents as supportive than friends. Only half of the subjects ($n = 13$) mentioned parents as a source of support. A 16-year old girl, for example, who had been sexually harassed by a work colleague told how she was grateful to her parents for having pressured her employer to move her to another working location so that she could avoid contact with the perpetrator. (P1) "My parents put a lot of pressure on my employer. They really supported me in this matter. (…). My employer said then that they would make sure that they got me away from this guy."

Eight participants said they had been supported by both parents, four only by their mother, and one only by her father. Three of those who mentioned only their mother as a source of support lived with their mother but not with their father. The participant who mentioned only her father as supportive lived with both parents.

Half of participants ($n = 13$) also said that talking to a counselor/psychotherapist had had a healing effect. A 16-year-old boy who had been sexually abused by an acquaintance for several months regarded psychotherapy as his most important source of support. (P20) "He helped me to cope with the abuse. I regularly saw my psychiatrist. We talked a lot."

Although it seemed that counseling was particularly important for those participants whose parents failed to emotionally support them, counseling was not regarded as a replacement for parental support, but as additional professional assistance for coping with SA. The above-quoted young man rated parental support and counseling as equally important for the coping process: (I) "Who did you get the most support from during this time?" (P20) "To be honest, from my parents and my psychiatrist. (…). They helped me to cope with everything that happened to me."

In addition to peers, parents and counselors, participants mentioned a variety of other people they received support from including intimate partners ($n = 8$), siblings ($n = 5$) and school staff ($n = 5$). The following quotations from three girls who were sexually abused by their fathers or step-fathers, demonstrate how different people can become an essential source of support for victims in the aftermath of SA as long as the latter trust them and feel backed by them. (I) "Is there anybody else who supports you?" (P6) "My boyfriend; he's very understanding." (P26) "My sister was on my side from the very beginning." (P14) "I can always talk to my teacher."

Table 3 also lists the types of support that participants said they had received. The vast majority said that it was helpful that they had somebody who was empathic: to whom they could talk; and who listened to them, understood their feelings and was there for them. Empathy was the most commonly-mentioned type of support provided by all groups of supportive people. For example, one boy (16-years-old) who had been sexually abused by his father answered the interviewer's question about how his girlfriend supported him: (P23) "Well, what does help? Well, if I feel bad, we talk together, I would say. Afterwards, I always feel better again." Talking to his girlfriend mitigated his feelings of shame and guilt: (P23) "I somehow don't feel that ashamed anymore and she tells me that it wasn't my fault."

A 17-year-old girl who had been sexually assaulted by a school friend found it very helpful that her mother was always there for her to talk to about the abuse: (P2) "My mother still supports me. We have the agreement that I can always go and talk to her if I don't feel well."

About one third of participants said that they had been referred to professional support such as a service for survivors of sexual violence, a psychotherapist, or a psychiatric institution. Referrals were most often made by their parents or counselors. The above-quoted 16-year old girl who had been abused by a work colleague and whose parents pressured her employer to separate her from the perpetrator at work, was also brought by her dad to the child protection team where she then was referred to a counselor.

> (P1) "My dad brought me to Ms. X from the child protection team. She then referred me to a psychologist. (…)."
> (I) "Did you want to see a counselor?"
> (P1) "Yes, to better cope with the trauma. (…). First I thought counselors are only for people who, I don't know. I thought I could just suppress it, but then everything was too much, you know, at the office."

With particular regard to peer abuse, female victims often mentioned how supported they felt if other young men were protective and took action against the perpetrator. The quotation from this 17-year old girl, who was sexually victimized by her boyfriend, indicates that support from male adolescents can reassure the victim's self-esteem and prevent her from generalizing her bad experiences to all males.

> (P11) "My male friends phoned the guy and told him to get his hands off me."
> (I) "And did you find it helpful that your friends behaved like that?"
> (P11) "Yes I found that very helpful. I'd had negative experiences with the male gender, but boys were also the ones who supported me so much."

Six participants found it helpful to solidarize with other SA survivors, to talk to them, and come to understand that they were not the only victims. Solidarity with other victims was mentioned primarily with regard to sexual assaults that had been

committed in a nightlife setting (e.g., bars, nightclubs) and was primarily sought with peers. This was the case with a 17-year-old girl who had been the victim of several sexual assaults by men she had met in clubs or bars. She had grown up in the countryside and was shocked by the aggressive sexual harassment demonstrated by some men when she began to explore nightlife in the city.

> (P13) "Some of my friends have experienced the same. We shared our experiences. We'd talk about them and think about ways we can protect ourselves and avoid any further assaults. (…). If you share your stories, you realize that other girls feel the same way you do. You realize that you are not the only person to whom something like that has been done."

Other behaviors that were experienced by participants as helpful included encouraging the victim to disclose SA experiences, reassuring them that they were not to blame for the assault, strengthening the victim's self-confidence, and assisting with coping. (P5) "She (a friend) always encouraged me to inform somebody about the abuse." (P6) "Well, that you finally understand that it was not your fault. I guess I would still blame myself if I had not had any therapy." (P9) "She (the participant's girlfriend) taught me to show my body again; that I don't have to be ashamed and to accept myself again." (P2) "She (the therapist) helped me not to suppress my feelings and to cope with everything."

Similar to the findings regarding referrals to professional support, parents again played a major role in providing assistance to initiate legal steps, such as reporting the assault to the police or contacting a lawyer. The following was offered by a 17-year-old girl who was raped by a school friend at the age of 14 when she was visiting the perpetrator at his home. She immediately disclosed the abuse to her mother, who quickly brought her to the police.

> (P22) "It was lunchtime and I should have been home a lot earlier. My parents called my friend and found out that I was not with her. They drove all through town looking for me. (After the sexual assault) I ran to the home of another friend who lived in the same area. And from there I called my parents (…). Then my mother came and I told her what had happened. And she said that we had to go to the police. And then they examined me—everything, the whole procedure."

Although the girl experienced the examination process as stressful, she was grateful that her mother reacted immediately and initiated legal steps, which the girl would not have been able to do on her own: (P22) "I found my mother reacted well to me being honest. Although at the beginning it was stressful; I just wanted to hide in the backmost corner and not see anybody."

Adolescent Statements About Insufficient or Absent Support

Although most participants said that they had received some kind of support, almost 80 % ($n = 20$) said that they felt they required more or better support. Additional support was primarily desired from parents. About two-thirds of participants ($n = 17$) complained about insufficient parental support (see Table 4) even though half the participants had been partly supported by their parents, as noted above.

Most often, participants complained that their parents did not show them enough empathy ($n = 15$). Adolescents missed having opportunities to talk with their parents about the assault and/or wished more empathic understanding from them that SA had seriously impacted their psychological well-being. A 15-year-old girl who was abused by her father when she was a child answered the interviewer's question about how her mother reacted when she disclosed the abuse 2 years ago:

> (P14) "Well, she just asked me exactly what had happened. But we have never talked about it. The thing is that I try to suppress it and then at night when I'm lying in bed, I start to cry. (…). The thing is that my mother doesn't want me to show that I am distressed. I feel under pressure that I have to be happy when I'm at home. She doesn't want me to cry. And so I cry during the night."
>
> After being asked whether she missed her mother's support, the girl continued: (P14) "Yes, sometimes yes. If she would just sometimes hug me."

The girl's narrative was impressive in showing how desperately lonely victims of SA feel if a parent is not able or willing to support them. Feeling alone and isolated from the rest of her family, the above-quoted girl tries to cope with the abuse by suppressing her anxiety, but did not completely succeed. At nights, she feels the pain of being left alone and cries herself to sleep.

Apart from the desire for more empathic support, almost one-third of participants ($n = 8$) said that a parent denied the abuse or did not believe them. In most cases, this was the mother who did not want to believe that her intimate partner had been abusing her child. Many of them seemed to feel somehow powerless and emotionally dependent on the perpetrator. An 18-year-old girl who was abused by her father for several years described how her mother played down the sexual assault in order to preserve her marriage and her family, as well as to maintain her perception of her husband as a good father:

> (P26) "She (her mother) doesn't take me seriously. She says that it wasn't abuse; that I should forgive him because he would only have wanted to treat me nicely. (…) I just have the feeling that she wants to suppress it because then it's easier for her. (…) She tells me how happy she is to go with him on holidays. (…). I would like to have more

Table 4 Persons perceived by participants as at least partly non-supportive and types of non-supportive behaviors

Persons perceived as (partly) non-supportive	Type of non-supportive behavior (N = number of participants who mentioned the specific non-supportive behavior)							
	Lack of empathy	Denying of SV	No protection	Emotionally instable	Short-term support only	Not realizing that the victim was in a bad state of mind	Blaming the victim	Taking the perpetrator's side
Parents (N[a] = 17)	15	8	8	8	5	3	1	2
Peers (N = 5)	3	–	–	–	1	–	2	–
School (N = 5)	1	4	2	–	–	–	1	–
Siblings (N = 3)	2	1	1	1	–	–	–	–
Counselor, psychotherapist (N = 2)	–	–	–	–	–	–	–	–
Intimate partner (N = 1)	1	–	–	–	–	–	–	–
Other people (N = 4)	2	1	1	–	–	2	–	1
Total[b]	17	11	9	8	5	5	4	4

SV sexual victimization

[a] Number of participants who mentioned a specific group of people as being (partly) non-supportive to them. *N* does not have to be equal to the total of types of non-supportive behavior that were mentioned for a specific group of people for two reasons: (1) multiple answers were possible and (2) Table includes only categories of types of non-supportive behaviors that were mentioned by more than two participants

[b] Number of participants who mentioned the specific type of non-supportive behavior independent of the group of non-supportive people. The total *N* does not correspond with the total of the mentions of a specific non-supportive behavior due to multiple answers

> support from my mother. (…). She also tells me that she doesn't want to separate from him, because she is afraid of rumors. She just wants people to think the best about our family."

Another third of the participants said that one of their parents did not protect them ($n = 8$). The above-quoted girl, who wished to receive more empathic support from her mother, was afraid because her father, who now lived separate from his family, sometimes stalked her when she went to school. She expected her mother to take action to protect her. However, her mother did not acknowledge the dangerous and frightening situation her daughter was in.

> (P14) "I don't understand it. My mum is afraid when I go out and return home late at night or so; then she's afraid. But she's not afraid of my father when I leave the flat early in the morning and he's waiting for me outside. That's when I am really scared."

One third ($n = 8$) also believed that their parents were too emotionally unstable to help them, either because they had already been in poor mental health before the SA happened or because they were not able to cope with the fact that their child had been sexually victimized. The mother of a 16-year-old girl who had been sexually assaulted by her mother's partner did not intervene, even though she witnessed the sexual assault. According to the girl, the mother was suffering from depression and therefore unable to take any action.

> (P18) "Then he came up from behind and touched my butt. (…) That happened to me two or three times. And once even in front of my mother. (…) He came and grabbed my breasts. Of course my mother didn't say anything; she was so depressed, she just couldn't do anything anymore."

Another common complaint from participants was that parents provided some support in the short-term, but ceased to do so after a while ($n = 5$). The narratives from these participants often indicated that parents underestimated the psychological consequences SA had for their child. One boy (age 6) and his brother were sexually victimized by a stranger. The two immediately reported this to their parents who then brought the children to a psychiatrist. However, after the consultation, the topic of SA remained taboo in the family. As a consequence, the boys did not get any further support from their parents: (P16) "We have never talked again about what happened in the family. I don't really know why. I think my parents just thought that once we had seen a psychiatrist, everything was okay again."

It was the first time in 11 years that this participant had spoken about his SA experiences. He participated in the study because he felt distressed by the fact that he never had had the opportunity to talk about the sexual assault. This finding shows that the absence of parental support can seriously impair a child's coping process.

Three participants also said that it would have helped if their parents had noticed that something was wrong with them. A 15-year-old girl was convinced that if the quality of her relationship with her parents had been better, they would have noticed that she was feeling distressed after she had been sexually victimized by school friends: (P3) "Our relationship has never been very close. My parents looked after me, but not in an emotional way. (…). Our relationship has never been that good that they would have noticed that I was very upset."

Finally, two participants wished that their mother would have taken their side and not the perpetrator's; and, in one case, parents blamed the participant, who had been raped by a childcare worker. (I) "And what kind of support would you have required at the time?" (P24) "I would have wished that my mum would not have backed him." (P10) "Once I wanted to tell my dad (about the rape). I was a bit unsure how I should express myself. He believed that I must have wanted it and then did not talk to me anymore. (…). I got very scared."

Albeit to a much lesser degree, some participants also were dissatisfied with support they received from other people such as friends, teachers or school social workers, siblings, and therapists. Again, the absence of opportunities to talk or to experience other empathic attitudes was most commonly regretted. A 17-year-old girl complained about a friend who did not understand that she still felt distressed after she had almost been raped by a school friend a few weeks earlier.

> (P2) "I know that it wasn't rape, but I also know that it was a bad experience. And I think this is something a lot of people don't understand. I have a friend who reacts irritated when I say something about the abuse. She says: 'You're still not over it? It's such a long time ago!' And then I always say 'No, I'm on my way, but not yet there'."

Again, this finding indicates how important the provision of emotional support for sexually victimized children and adolescents is, and that it needs to be provided by several members of the victim's social network.

What is Most Necessary for Survivors of Sexual Victimization?

When asked what kind of support was most necessary to them or would have been most important in helping them cope with SA, most participants mentioned specific people who supported them. Ten participants mentioned support from their parents, six mentioned support from their friends, five from psychotherapy, and one each from their grandmother, their intimate partner, and their pets. Once again, findings demonstrate that parental support was often inadequate. For example, the boy mentioned earlier who was sexually assaulted with his brother by a stranger when they were children emphasized again that he would have profited mostly from more parental support: (I) "What do you think would have helped most at the time?" (P16) "I would have definitely needed more support from my parents."

Independent of the specific person who provided support, participants rated emotional support as most important in helping someone cope with SA. A 17-year-old girl who was raped by her boyfriend when she was 14 found it most helpful for coping with the abuse that her parents were always there for her: (I) "What was the most important thing your parents did for you?" (P19) "Listening to me. (…) And that I could always phone them when I was scared."

Participants were also asked what they thought victims of sexual violence in general need. Once again, somebody who understands and to whom they can talk to was the most frequent response ($n = 11$). A 16-year-old girl who had been abused by her father answered: (P21) "That somebody is there for you, somebody you can trust in, somebody you can talk to."

These findings confirm the results presented above on adolescents' perception of received and inadequate support. Empathy seems to be one of the most important types of support required by survivors of SA.

In addition to empathy, support from parents ($n = 7$) and professional psychological support ($n = 6$) were deemed crucial. Once again, one girl (age 16) who had been sexually assaulted by her mother's partner stated how essential parental support is: (I) "What do you think victims of sexual violence need in general?" (P8) "Support." (I) "From whom?" (P8) "In the first place are always parents."

Factors Associated with Perceived Support

Results of associations tested between the characteristics of SA and perceived support are shown in Table 5. Intra-familial SA was significantly positively associated with complaints of insufficient support ($r = .37$, $p = .01$, $df = 24$). All participants with no complaints of lack of support ($n = 6$) had experienced extra-familial SA. There was a statistical trend that more severe SA was negatively associated with general support ($r = .33$, $p = .10$, $df = 24$), as well as with support from peers ($r = .34$, $p = .09$, $df = 24$). Age when SA first happened was significantly related to insufficient support as follows: the younger participants were when first sexually victimized, the more they complained of insufficient support in general ($r = -.36$, $p = .01$, $df = 24$) and of insufficient support from parents ($r = -.46$, $p = .02$, $df = 24$). There were also certain statistical trends between the age of the perpetrator and insufficient support: if the perpetrator was an adult, participants were generally less satisfied with support ($r = .37$, $p = .07$, $df = 24$). Finally, there was a statistical trend that participants mentioned a greater number of groups of unsupportive people if an adult committed SA ($r = .33$, $p = .10$, $df = 24$).

Table 5 Results of correlation analyses (Spearman rhos)

Characteristics of SA	Variables related to perceived support				
	Insufficient support	Insufficient support from parents	Insufficient support from peers	Insufficient support from school?	No. of groups of unsupportive persons
Intrafamilial SA	.37*	.14	−.12	−.11	.15
Age at SA	−.36*	−.46*	−.05	.08	.00
Penetrative SA	.25	24	.22	.22	.00
Severity of SA	.33†	.31	.34†	.23	.16
Singular SA	−.21	−.02	−.06	−.06	−.12
Age of perpetrator <18 years	.37†	.24	−.29	.10	.33**

SA sexual abuse

* $p \leq .05$; ** $p < .01$; † $p \leq .10$

Discussion

This study contributed important empirical findings to a sorely neglected area of research on SA of children and adolescents. It was the first study that comprehensively examined perceived social support in the aftermath of SA in a non-clinical sample of sexually-victimized adolescents using a qualitative, face-to-face, in-depth interview. Although previous studies with adults or clinical samples of referred children have indicated that many children do not receive adequate support following SA (e.g., Hershkowitz et al., 2007), this study explored in detail what type of support the children actually required and which members of their social network were most required in the provision of different types of support. This knowledge is important to improve social support after SA and, thereby, to alleviate negative repercussions of SA on children's mental health (Yancey & Hansen, 2010).

On the whole, the results of this study confirmed our thesis that sexually-victimized children and adolescents require a network of socially-supportive people providing different aspects of social support, and that victims often perceive received support as insufficient for coping with the abuse.

Most adolescents said that they had received some support, with peers seen as the most reliable source. Least frequently mentioned as providers of support were relatives other than parents such as siblings and school staff. Most striking was that the majority of participants complained of insufficient support from their parents. This finding was in line with results from studies on adult survivors of child SA, which have consistently shown that parents often react in an unsupportive manner towards young victims of SA, even in cases of extra-familial abuse (e.g., Roesler & Weissmann Wind, 1994). By contrast, the qualitative interview study by Crisma et al. (2004) and several other studies that investigated children referred to local authorities (e.g., Lovett, 1995) found that most children were satisfied with parental support. It is possible that this inconsistent finding reflected the relative support offered by participants' parents in the different samples. Another plausible explanation for this discrepancy in findings may be that the studies with positive findings only examined parents' immediate reactions to the child's disclosure, while the current study and studies on adults also investigated long-term support. A considerable number of participants in our study complained that parents initially reacted supportively, but that this did not last. Furthermore, it is likely that parents of referred children tended to be more supportive of their child than parents who failed to bring their child to the attention of local authorities. Such discrepancies in findings illuminate the importance of recruiting children and adolescents from the general population, as we did in our study, in order to avoid such bias.

Why were our subjects so much less satisfied with parental support than with support from their friends? On the one hand, it could be assumed that the extent and quality of peer support indeed exceeded parental support. Participants often described unsupportive reactions from parents (see above), suggesting that parents often felt unable to cope with the fact that their child had been sexually abused. Rogers and Terry (1984) and McGuffey (2008) described how negative parental responses to SA can only been understood within the cultural context they live in and are influenced by stereotypes about gender and sexuality. The complexity of the parents' motives not to respond to SA in a supportive way has not yet been examined and needs to be investigated in future studies. On the other hand, participants may have expected better support from their parents than from their friends because they rated parental support as most important to them in being able to cope with the abuse. Due to higher expectations, parents may have been at greater risk of disappointing their child than peers were. Our impressions from the interviews suggested that both explanations might have contributed to the relatively negative assessment of parental support.

The most frequently mentioned type of support that parents failed to provide was empathic behavior such as listening and being there for the child. This finding suggests that many parents

were not aware of the devastating repercussions SA can have on a child's psychological well-being. On the other hand, some parents might have been aware of the potentially adverse consequences but felt too overwhelmed to show empathic helping behavior. However, this finding is particularly notable since adolescents rated emotional support as most important to their coping with SA. Also, Crisma et al. (2004) reported that young survivors of SA see empathic responses by recipients of disclosure as significant to the coping process. Our study showed that this basic need for empathic understanding is often not met by the victims' social network.

Apart from empathy, one of the types of supportive behavior most frequently mentioned by participants was referral to a professional service such as counseling. Most of the referred participants had good experiences with counseling and found it very helpful. Referrals were most often made by adults such as parents or teachers, while none of the participants was referred to a professional by a friend. This finding showed how support from parents and other adults cannot be replaced entirely by peer support. Peers primarily seemed to provide emotional support, and may not be confident or knowledgeable enough to provide instrumental support such as referrals to professional services.

The importance of professional psychological support was also confirmed in the studies of Morrison and Clavenna-Valleroy (1998) and Crisma et al. (2004). Morrison and Clavenna-Valleroy reported that about one third of the examined children found it helpful that their mother had referred them to psychotherapy. Adolescent participants in the study by Crisma et al. regarded counseling as essential to the coping process but were often dissatisfied with counselors' non-empathic reactions to disclosure. The latter finding contradicted the experiences of participants in the current study, who were generally satisfied with counselors. There could be several explanations for these disparate findings including differences in the type of counseling received, differences in the training of counselors, or differences regarding sample characteristics.

With regard to non-supportive attitudes, participants also complained that some members of their social network denied or minimized SA, failed to protect them from the perpetrator, or were too emotionally distressed to provide support. This criticism mainly concerned mothers who were in a love relationship with the perpetrator, but in some cases included teachers and school social workers. That in particular mothers who are in an amorous relationship with the perpetrator sometimes feel too powerless to protect their child has been demonstrated in previous research (Sirles & Franke, 1989). On the other hand, it is also likely that some mothers did indeed not recognize the abuse and thus did not take any action against their partners' abusive behaviors. There may be two reasons that participants mainly blamed their mothers for not having recognized the abuse, and much less so their fathers: Firstly, women sexually abuse children and adolescents much less often than men. Thus, fathers are much less likely to be in a relationship with an abusive partner than mothers. Secondly, participants talked much more about supportive and non-supportive behaviors from mothers than from fathers, indicating that maternal support was considered as more important due to closer relationships. Notably, it would be wrong to conclude from our results that the majority of mothers were guilty of denying the SA of their child. Most of them took some form of action in support of their child. However, in some cases they might not have felt courageous enough to support their child appropriately or simply did not know how to provide appropriate support. Provision of support might have been particularly difficult for mothers who were in a love relationship with the perpetrator.

This study also investigated quantitative associations between the characteristics of SA and adolescents' perceptions of received support. Adolescents complained more frequently about insufficient support if the perpetrator was a family member. Since the perpetrator was the mother's spouse in most cases of intra-familial abuse, this association might be explained by the above-discussed conjecture that mothers are sometimes not able to recognize the abuse to preserve their own love relationship with the perpetrator.

There was also a significant positive association between the age of the victim when SA started and their satisfaction with received support. This result is consistent with results reported by Everson et al. (1989), but contradicts the findings of Rosenthal et al. (2003) and Sirles and Franke (1989), who reported that younger children tend to receive more support in the aftermath of SA than adolescents. Everson et al. argued that the younger children in their sample had been more often subjected to intra-familial SA than the adolescents, and thus may have been less supported. This explanation also might apply to the current study. Participants who experienced SA in adolescence were most likely to have experienced SA at the hands of a peer. This explanation would also be compatible with the finding that participants victimized by adolescent perpetrators received more support than those victimized by adults. However, one could also argue that adolescents, relative to younger children, have the cognitive skills to comprehend what has happened to them and, therefore, are more likely to disclose the abuse and ask for help. Our data on disclosure is presented elsewhere (Schönbucher et al., 2012) and revealed that younger children were less likely to disclose SA experiences than adolescents.

Overall, these findings showed that young children may be at particularly high risk of not receiving adequate support and, thus, of developing mental health problems—a finding that was not observed by Rosenthal et al. (2003) or by Sirles and Franke (1989), who examined referred children and adolescents. This again indicates that studies with SA survivors from the general population can bring to light different results than studies with clinical samples, which are more prone to statistical bias. Hence, it is important for future research to re-examine results from previous studies that examined referred cases using samples of

sexually victimized children and adolescents from the general population, as we did in our study.

A final result from the correlation analysis was that more severe types of SA were negatively associated with satisfaction of received support. This same association has been observed by others (e.g., Sirles & Franke, 1989), but not all (see Bolen, 2002). One explanation for such an association might be that children and adolescents who experience severe SA feel a stronger need for support than children and adolescents after non-contact SA and, therefore, are less satisfied with the support they receive. On the other hand, it is known from previous studies (e.g., Hershkowitz et al., 2007) that children and adolescents are less likely to disclose abuse after severe SA than after less severe abuse, and may receive less social supported for this reason. Certainly, the association between severity of SA and the provision of support should be studied in greater detail in future studies as young victims of severe SA may be particularly unable to cope with abuse if reliable support is lacking.

Study Limitations

Although we reported a methodologically sound study combining both qualitative and quantitative research methods and demonstrating excellent intercoder reliability, certain limitations must be mentioned. Due to small samples sizes, samples in qualitative research are never representative and, therefore, are prone to selection bias. The finding, for example, that all but one participant had previously disclosed experiences of SA suggested that non-disclosing adolescents were less willing to participate in our study. Another bias could have been caused by the fact that about one third of participating adolescents sought advice from the interviewer and took advantage of our offer of short-term counseling. It can be assumed that adolescents who were looking for support were particularly likely to participate in our study.

Furthermore, the participation rate of male adolescents was much lower than that of girls. It is known from previous research and practice that boys are more hesitant to disclose SA than girls are, probably due to fears of being deemed homosexual (Paine & Hanson, 2002) and in defence of their self-image as strong and invulnerable males (Richter-Appelt, 2002). Due to these lower disclosure rates, boys may be less likely to participate in SA research than girls. Unfortunately, the participation of just three males did not allow us to analyze possible gender differences in perceptions of received support. It is possible that boys have a need for other types of support than girls (e.g., they might be less likely to actively seek out someone to talk about SA and, thus, might be more dependent on someone who actively asks them about their negative sexual experiences). Moreover, research findings have indicated that boys are more frequently abused by female perpetrators than girls (Edgardh & Ormstad, 2000; Halpérin et al., 1996). Boys who have been sexually abused by female perpetrators might be more open to support from males than females. There might also be differences regarding the need for support between children of the same gender. Future research is required to examine individual differences between sexually victimized children and adolescents with regard to the types of support required.

Further, some recollection bias may have influenced the study. Even though surveying adolescents is the most accurate way to do research on SA of minors (London et al., 2008), accounts from adolescents still bear the risk of retrospective bias. In particular, adolescents who were abused in early childhood may not have been able to remember the exact amount of support they received.

Another limitation of our study refers to the assessment of social support. Qualitative in-depth interviews focus on giving participants a voice to express their subjective experiences and perspectives and do not aim to generate objective information. It is likely that people in our participants' social networks made some efforts to provide support that were not perceived as supportive behavior by participants or that participants forgot to mention in the interviews. Therefore, our findings might have underestimated the social support provided to participants. Moreover, it was not possible to control for each potential source of support in the participants' social network, whether participants actively sought out and asked a particular person for support, or whether they expected more support without being able to express their needs. Such complex analysis could only be achieved by a quantitative assessment and by involving people within the participants' social networks, so as to evaluate their own perspectives of support provided. Moreover, there was a yes/no bias built into several questions by using yes/no leading questions instead of using questions that allowed open answers. This may have biased participants' answers in a yes-direction.

Limitations exist not only pertaining to data assessment but also with regard to qualitative data analysis. Mayring's (2008) content analysis is a descriptive research approach and does not allow for interpretative analysis. It was useful for examining how well participants felt supported by the various people within their social network, what kind of support they found helpful, and what types of behaviors participants experienced as non-supportive. However, our approach did not allow for any in-depth analysis of the interactions between participants and potential support providers, participants' emotions surrounding their feelings of insufficient support, and what it meant to participants if somebody did provide helpful support. Such questions require interpretative research methods such as interpretative phenomenological analysis (Smith et al., 2009). Future studies should also focus on the investigation of how support influences children's and adolescents' psychological development, and particularly the protective effect of support on psychosexual development.

A final shortcoming of our study should be mentioned. Although the size of our sample was relatively large for qualitative analysis, it was rather small for correlation analysis. However,

since the likelihood of statistically significant results lessens as samples become smaller (Bortz & Lienert, 2008), it is presumed that the associations found in this study were not overestimating true associations.

Implications for Practice

As discussed above, the narratives of the young survivors of SA participating in this study revealed that they felt a need for better access to a more reliable social network that consisted of several people who provided different kinds of support. Since perception is key when recovering from trauma (Janoff-Bulman, 1992), the findings of this study suggested several preliminary strategies for improving rehabilitation after SA. As a first implication for promoting recovery after SA, we would suggest that parents should be taught the importance of providing emotional support for their child. How long a child needs emotional support following SA may be individual and depend on several factors such as the severity of CSA, the child's relationship with the perpetrator, and the child's interpretation of the SA. To date, empirical evidence on ideal length of support is lacking. However, as current prevention programs mainly focus on raising parents' awareness of SA and encouraging them to interrupt SA (e.g., Vermont Department for Children and Families, 2010), future prevention programs should more intensively address the importance of long term emotional support for the child's mental health needs. Particularly in Switzerland, the awareness of services that offer counseling for parents of sexually victimized children should be heightened so that parents are aware of where they can find help in supporting their child. In cases where the mother's partner has been the abuser, mother–child interventions should be promoted, aimed at restoring trust between the child and her/his mother (Bratton, Ceballos, Landreth, & Costas, 2012).

Secondly, children and adolescents should be taught in school about how to react if a friend discloses SA to them. In particular, they should be informed about readily available counseling services for young survivors of SA where victimized friends can find help. Counseling was considered by our study participants to be a very important source of support. However, most participants only saw a counselor if they had been referred by someone else. Since peers have been perceived by adolescents to be the most reliable providers of support, they could play an important role in the facilitation of access to professional support if they are adequately informed about available services.

Finally, only a minority of participants said that they had received any support from teachers or school social workers. This finding indicates that schools in Switzerland need to improve their support for young survivors of SA. As advised by current school prevention programs (e.g., Vermont Sexual Violence Prevention Task Force, 2010), children and adolescents should not only be taught about the nature of SA and available sources of support outside of school, they should be encouraged to inform a teacher if they have either experienced or been threatened with SA. School staff needs specifically to be trained to raise teachers' awareness of SA and to improve their ability to provide adequate support. Especially in cases in which parents fail to provide the necessary support, teachers may play an important role in the provision of adult support. Only if support for victims of SA improves can disclosure rates of SA be increased and repercussions for mental health minimized.

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